



STATE OF MARYLAND

# DHMH VOLUNTEER CORPS CONTACT INFORMATION

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – S. Anthony McCann, Secretary

**Yes, I am willing to volunteer my time to provide medical care in an emergency situation.**

*\*Please note that the information you are providing is confidential and will be available only to people authorized to access data through this program.\**

| NAME | LICENSE NUMBER | SPECIALTY/PRACTICE AREA |
|------|----------------|-------------------------|
|      |                |                         |

HOME ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

HOME COUNTY: \_\_\_\_\_

NAME OF PRACTICE: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_

CITY, STATE ZIP: \_\_\_\_\_

WORK COUNTY: \_\_\_\_\_

|                  |             |             |
|------------------|-------------|-------------|
| HOME PHONE:      | CELL PHONE: | WORK PHONE: |
| HOME FAX:        | PAGER:      | WORK FAX:   |
|                  | PIN:        |             |
| ALTERNATE PHONE: |             |             |

| PERSONAL EMAIL ADDRESS | BUSINESS EMAIL ADDRESS |
|------------------------|------------------------|
|                        |                        |

**PLEASE PROVIDE THE NUMBER(S) THAT SHOULD BE USED IN THE EVENT OF AN  
ACTUAL EMERGENCY:**

DAYTIME PHONE: \_\_\_\_\_ NIGHTTIME PHONE: \_\_\_\_\_

Would you be willing to become a volunteer trainer? YES \_\_\_ NO \_\_\_ MAYBE \_\_\_

—OVER—

*Tell us about any particular training and/or experience you have regarding any of the specific agents:*

\_\_\_\_\_ Chemical      \_\_\_\_\_ Biological      \_\_\_\_\_ Radiological      \_\_\_\_\_ Nuclear

*Please circle any disease(s) you have worked with or have any specialized knowledge of:*

**MENINGITIS**

**TUBERCULOSIS**

**SMALL POX**

**ANTHRAX**

**HEPATITIS**

**WEST NILE**

**MALARIA**

**LYME**

**AVIAN INFLUENZA**

LIST ANY OTHER DISEASES: \_\_\_\_\_

**List any Language Skills, including American Sign Language, and proficiency:**

\_\_\_\_\_: **SPEAK** \_\_ **READ** \_\_ **WRITE** \_\_  
\_\_\_\_\_: **SPEAK** \_\_ **READ** \_\_ **WRITE** \_\_  
\_\_\_\_\_: **SPEAK** \_\_ **READ** \_\_ **WRITE** \_\_

☐ *Check here if you are willing to serve in any area.*

If you are not willing to serve in any area, please list the counties in which you would prefer to volunteer:

**If feasible, would you be willing to travel overseas to volunteer in the event of a disaster? YES \_\_ NO \_\_**

**Are you committed to any other volunteer organizations in the event of a disaster? YES \_\_ NO \_\_**

**If so, please list:** \_\_\_\_\_

**How did you learn about the Maryland Professional Volunteer Corps?** \_\_\_\_\_

**Authorization Statement:**

I, (print name) \_\_\_\_\_ authorize this information to be submitted to the Maryland DHMH Professional Volunteer Corps database and be made available for volunteer disaster response activity at state and local levels.

\_\_\_\_\_  
(Signature and Date)

**Please Return to:**

Maryland Board of Physicians  
Attn: Emergency Preparedness  
4201 Patterson Ave.  
Baltimore, MD 21215

Fax: (410) 358-2252